



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-17-0786-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

November 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 99284, allowed amount of \$287.54 multiplied at 200%, CPT Code 71010, allowed amount of \$53.46 multiplied at 200%, CPT Code 72040, allowed amount of \$88.54, multiplied at 200%, CPT Code 93005, allowed amount of \$49.19, multiplied at 200%, CPT Code 73562, allowed amount of \$53.46, multiplied at 200% and CPT Code 96360, allowed amount of \$81.25, multiplied at 200% reimbursement should be \$1,226.88. Payment received was only \$844.50, thus according to these calculations; there is a pending payment in the amount of \$382.38"

Amount in Dispute: \$544.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$844.50."

Response Submitted by: ESIS Bill Review, 1851 E 1st St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2016	96360, 72040, 73562, 93005	\$544.88	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 222 – Charge exceeds Fee Schedule allowance
 - 774 – CMS OPPTS STVX-packaged service is packaged into the payment for the service(s) with status indicator S, T, V or X and no separate payment is made for the STVX-packaged service
 - 785 – Items and/or services are packaged into APC rate. Therefore no separate APC payment
 - ANSI 193 – Original payment decision is being maintained. This claim was processed properly the first time
 - ANSI P12 – Workers compensation jurisdictional fee schedule adjustment
 - CIQ 378 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time

The requestor is seeking reimbursement of \$544.88 for outpatient hospital services rendered on May 27, 2016. Outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS. In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPTS services, which are:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
 - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPTS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPTS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPTS Addenda, Addendum D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPTS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment

amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Issues

1. What is the applicable rule that applies to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier reduced the services in dispute with P12 – “Workers compensation jurisdiction fee schedule adjustment.” 28 Texas Administrative Code §134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

The MAR for code 96360 is calculated as follows:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index 0.7989	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
96360	S	5693	\$92.40	\$92.40 X 60% = \$55.44	\$55.44 X 0.7989 = \$44.29	\$92.40 X 40% = \$36.96	\$44.29 + \$36.96 = \$81.25	\$81.25 X 200% = \$162.50
							Total	\$162.50

The remaining services listed on the DWC060 have the following classifications:

- Procedure code 72040 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. As code 96360 has a status indicator of “S” no separate payment available. The carrier denied with code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” The carrier’s denial is supported.
- Procedure code 73562 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. As code 96360 has a status indicator of “S” no separate payment available. The carrier denied with code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” The carrier’s denial is supported.
- Procedure code 93005 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. As code 96360 has a status indicator of “S” no separate payment available. The carrier denied with code 97 – “The benefit for this service is included in the

payment/allowance for another service/procedure that has already been adjudicated.” The carrier’s denial is supported.

2. The total allowable reimbursement for the rendered services is \$844.50. This amount less the amount previously paid by the insurance carrier of \$844.50 leaves an amount due to the requestor of \$0.00. No additional reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	December 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.